PERCEPTIONS OF QUALITY OF LIFE AND EXPERIENCES OF VIOLENCE IN THE ELDERLY

PERCEPÇÕES DE QUALIDADE DE VIDA E AS EXPERIÊNCIAS DE VIOLÊNCIAS EM IDOSOS PERCEPCIONES DE CALIDAD DE VIDA Y LAS EXPERIENCIAS DE VIOLENCIAS EN ANCIANOS

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ABSTRACT

Objective: to describe experiences of violence and self-perception of quality of life and health after 60 years of age. **Method:** quantitative, cross-sectional and descriptive study developed with 100 elderly. Data collection was used for the Quality of Life (WHOQOL-BREF), Mental State Assessment and questionnaire on the occurrence of violence. **Results:** there was a higher frequency of female elderly (62%), incomplete primary education (43%) and family income up to a minimum wage (46%). More than half of the elderly (62%) reported not having a good quality of life, and 38% described feelings compatible with despair, anxiety and depression. It was observed that 73% suffered some form of violence, including insult and discrimination (40% and 35% respectively), abandonment (31%), financial abuse (15%) and physical aggression (12%). There was no relation between suffering violence and self-perception of health and quality of life (p-value 0.5587). **Conclusion:** the importance of the identification and magnitude of violence in this population segment is highlighted, since interdisciplinary and intersectoral interventions need to be articulated with the health sector and, thus, to favor the protagonism of the elderly in confronting violence. **Descriptors:** Violence; Aged; Quality of Life; Exposure to Violence; Self Concept; Social Determinants of Health.

RESUMO

Objetivo: descrever as experiências de violências e a autopercepção da qualidade de vida e saúde após os 60 anos de idade. **Método:** estudo quantitativo, transversal e descritivo desenvolvido com 100 idosos comunitários. Utilizaram-se, para a coleta de dados, os instrumentos Qualidade de Vida (WHOQOL-BREF), Avaliação do Estado Mental e questionário sobre a ocorrência de violências. **Resultado:** constatou-se uma maior frequência de idosos do sexo feminino (62%), com ensino fundamental incompleto (43%) e renda familiar de até um salário mínimo (46%). Mais da metade dos idosos (62%) declarou não ter uma boa qualidade de vida e 38% descreveram sentimentos compatíveis com o desespero, a ansiedade e a depressão. Observou-se que 73% sofreram algum tipo de violência destacando-se o insulto e a discriminação (40% e 35%, respectivamente), o abandono (31%), o abuso financeiro (15%) e a agressão física (12%). Não se observou relação entre sofrer violência e autopercepção de saúde e qualidade de vida (p-valor de 0,5587). **Conclusão:** destaca-se a importância da identificação e magnitude das violências nesse segmento populacional, pois as intervenções interdisciplinares e intersectoriais precisam estar articuladas com o setor saúde e, assim, favorecer o protagonismo do idoso no enfrentamento às violências. **Descritores:** Violência; Idoso; Qualidade de Vida; Exposição à Violência; Autoimagem; Determinantes sociais de Saúde.

RESUMEN

Objetivo: describir las experiencias de violencias y la autopercepción de la calidad de vida y la salud después de los 60 años de edad. **Método:** estudio cuantitativo, transversal y descriptivo desarrollado con 100 ancianos comunitarios. Se utilizaron los siguientes instrumentos para la recolección de datos: Calidad de Vida (WHOQOL-BREF), Evaluación del Estado Mental y cuestionario sobre la ocurrencia de violencias. **Resultados:** se constató una mayor frecuencia de ancianos del sexo femenino (62%), con enseñanza básica incompleta (43%) y renta familiar de hasta un salario mínimo (46%). Más de la mitad de los ancianos (62%) declaró no tener una buena calidad de vida y 38% describieron sentimientos compatibles con la desesperación, la ansiedad y la depresión. Se observó que el 73% sufrieron algún tipo de violencia, destacándose el insulto y la discriminación (40% y 35%, respectivamente), el abandono (31%), el abuso financiero (15%) y la agresión física (12%). No se observó relación entre sufrir violencia y autopercepción de salud y calidad de vida (p-valor de 0,5587). **Conclusión:** se destaca la importancia de la identificación y magnitud de las violencias en ese segmento poblacional, pues las intervenciones interdisciplinares e intersectoriales necesitan estar articuladas con el sector salud y, así favorecer el protagonismo del anciano en el enfrentamiento a las violencias. **Descriptor:** Violencia; Anciano; Calidad de vida; Exposición a la Violencia; Autoimagen; Determinantes Sociales de la Salud.

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INTRODUCTION

Violence against the elderly is considered to have a global and local impact and causes physical, psychological, moral and spiritual damages interfering with the perception of quality of life and health.¹⁻²

The terms violence or elder abuse are used synonymously and can be defined as a single or repeated act that occurs within any relationship in which there is an expectation of trust and which causes harm or distress to an elderly person. Violent acts, even when they are not fatal, undermine the quality of life, are responsible for physical and mental aggravations, and often leave their victims with sequels of varying intensity.³

It is known that the quality of life and health are multidimensional and subjective concepts, difficult to be measured, since they represent an evaluation based on subjectivities, temporalities, individualities, cultural variations, socio-normative and social position.⁴⁻⁵

It is verified that community studies about the quality of life of elderly people are still scarce.⁶ Research with the elderly population indicates: the importance of family ties; social relationships; Cheers; life without violence; physical activity; psychological well-being; spirituality; self-esteem and personal well-being; access to financial resources; good neighborly relations to promote the quality of life in old age.⁶⁻⁷

It is understood that the identification of violence and the subjectivity of the perception of quality of life and health tend to be influenced by several aspects such as socioeconomic level, social interaction, family support and satisfaction with life. In addition, it is understood that situations of violence negatively affect the perception of quality of life and are associated with mental and behavioral disorders such as depression, anxiety, insomnia, among others.⁸⁻⁹

On the international scene, a study is presented with data from 28 peripheral economy countries, where there is an estimate that every six elderly people are victims of violence and affirms that violence against the elderly represents a neglected problem in the agenda of global health priority.¹⁰

OBJECTIVE

- To describe the perception of elderly people about their health, quality of life and experiences of violence after completing 60 years.

METHOD

It is a quantitative, cross-sectional and descriptive study developed in a socioeconomically vulnerable region of the Metropolitan Area of Brasília (MAB), in the Federal District (DF).

They were listed as criteria for inclusion in the sample composition: age 60 years or older; being of both sexes; be enrolled in the Center of Coexistence of the Elderly (CCE) of the MAB chosen for the study and have no diagnosis of any type of dementia.

Data were collected through individual face-to-face interviews, in a private setting, in one of the CCEs rooms or in the elderly's home, according to the preference of the participant, from March to July 2015. The interviews had an average duration of 50 minutes.

A questionnaire validated in previous studies was used to identify sociodemographic characteristics, life context and violence occurrences.^{9,11}

A cognitive function assessment instrument was applied - the second edition of the Mini-Mental State Examination (MMSE), which represents a scale to aid in the tracking and investigation of cognitive deficits in people at risk of developing a dementia syndrome. The scores of the instrument were adapted to Brazil according to the schooling levels.¹²

Two questions from WHOQOL-BREF regarding self-perception about quality of life and health were chosen to analyze the perception of quality of life of the elderly: "How do you evaluate your quality of life?" And "How satisfied are you with your health?".¹³

The data was entered in an Excel spreadsheet and the R software was used for the analysis of the descriptive statistics, where the frequencies, the distribution and the relations between the variables were obtained by means of the chi-square test, with level of significance 0.05. Inferential statistics were performed for the two groups on the likert scale: elderly people who declared a good or very good quality of life and who are satisfied or very satisfied with their health and elderly people who do not have a good quality of life and are not satisfied with health. These two groups were analyzed according to the experience of having suffered some kind of violence.

The research was approved by the Research Ethics Committee of the Faculty of Health Sciences of the University of Brasília (UnB) under the number of the Certificate of

RESULTS

It is reported that the final sample consisted of 100 elderly people. It was observed that the largest proportion of the elderly belonged to the age group between 60 and 69 years (51%), was female (62%), low schooling (43%) and low family income (46%), according to table 1.

It is revealed, as far as the cognitive performance measured by the MMSE, that 100% presented normal score in the score according to the schooling.

It complements, with regard to the current occupation, that 66% affirmed to be retired or pensioners. Regarding the origin, the Northeastern region of Brazil corresponded to almost half of the interviewees (48%), with only 19% of them from the Central-West region. Regarding self-perception of health, 51% answered that they considered their state of health as regular or poor, according to table 1.

It was also observed that, although 80% reported being in medical treatment for some type of chronic non-transmissible disease, 76% evaluated that physical pain did not prevent them from performing the basic activities of daily living.

It was noticed that the urban environment in which the elderly lived was perceived by the majority as healthy (84%) and more than half of the respondents stated that they were satisfied with the conditions of the place where they lived (60%). However, 33% stated that they did not have the opportunity for leisure activities at the place of residence.

It should be noted that when asked the elderly specifically about the quality of access to health services and transportation services, they were perceived as bad for 70% and 82%, respectively.

As regards the support network, 77% of the elderly reported living with at least one relative, 93% had children, but only 34% participated in some social activity more frequently, according to table 2.

It is detailed, on the experiences of mistreatment, that the violence of psychological nature was the most reported by the interviewees. The insults corresponded to 40% of the cases and the discrimination situations were reported by 35%. When questioned about the frequency of violent acts, 23% reported that the episodes of insults were very frequent, which reveals not to be

an isolated episode, but a continuum of violence in the lives of these elderly people. Regarding the temporality of the occurrence of the aggressions suffered, 51% stated that the discrimination occurred in the last 12 months and, therefore, represented episodes of recent violence, according to table 3.

Self-inflicted neglect was reported by 26% of the elderly and 31% reported having felt abandoned after 60 years of age. As for the frequency of feeling abandoned, almost a third (32.3%) stated that this occurred on many occasions. Sexual violence was reported by 4%, according to table 3.

It should be noted that only 24% of all interviewees perceived health and quality of life as good and very good, 76% of which identified both as "not good and not bad"; "Bad and very bad". The occurrence of lived experiences of violence was observed in both groups and there was no association between experiences of violence and different perceptions about health and quality of life ($p = 0.8982$), according to table 4.

It is pointed out that inferential analysis, which sought to identify whether the perception of quality of life and health as "good and very good" would increase the chance of non-occurrence of violence, found that there was a 0.956-fold greater chance of belonging to the group who did not suffer violence compared to the elderly who had been ill-treated.

It was verified that the experiences of violence occurred in both groups and the sample number of the study presented limitations for more robust analyzes, especially to the detriment of the number of interviewees who did not have a definite position at the time of the interview or were not able to classify, specific way, their quality of life and health chose to describe it as "neither good nor bad" (40%) and having been excluded in inferential analysis.

Table 4 shows that there is a greater proportion of elderly people dissatisfied with health and quality of life, approximately 60%, than those who declared themselves satisfied and in good health. The high prevalence of experiences of violence identified in the study reveals the seriousness of the problem of violence against the elderly. It is noteworthy that 73% of those interviewed said they had experienced some situation in which they experienced at least one type of violence in old age. Of the elderly selected for inferential analysis, 78.3% suffered some type of violence after 60 years of life.

Table 1. Distribution of sociodemographic variables and life context of the elderly in a Metropolitan Area of Brasília, DF, Brazil, 2016 (n = 100).

Variables	n	%
Age group (years)		
60 to 69	51	51.0
70 to 79	32	32.0
80 or more	17	17.0
Sex		
Female	62	62.0
Male	38	38.0
Geographical Provenance		
Northeast	48	48.0
Southwest	24	24.0
Midwest	19	19.0
North	7	7.0
South	2	2.0
Race/color		
Brown/Black	74	74.0
White	18	18.0
Yellow	8	8.0
Marital status		
Divorced	53	53.0
Married/stable union	37	37.0
Single	10	10.0
Education		
Incomplete Elementary school	43	43.0
Illiterate	41	41.0
Complete elementary school	9	9.0
Complete high school or higher education	5	5.0
Does not know/does not remember	2	2.0
Work situation		
Retired/pension	66	66.0
Government welfare	15	15.0
Working	10	10.0
Others	9	9.0
Alcoholic drinks		
No	78	78.0
Yes	22	22.0
Perception of health		
Bad	12	12.0
Regular	39	39.0
Good	32	32.0
Great	17	17.0
Treatment for a health issue		
Yes	81	81.0
No	19	19.0
Total	100	100.0

Table 2. Distribution of the elderly support network in a region of the Metropolitan Area of Brasília, DF, 2016 (n=100).

Variable	Category	n	%
Lives with children or family members	Yes	77	77.0
	No	23	23.0
Has children	Yes	93	93.0
	No	7	7.0
Participate in any group or activities with others other than the Center for Coexistence	Yes	34	34.0
	No	66	66.0
Satisfaction with personal relationships with friends, relatives, acquaintances or colleagues	Yes	59	59.0
	No	41	41.0
Total		100	100.0

Table 3. Distribution of experiences of violence according to the nature, prevalence and frequency of the elderly in a region of the Metropolitan Area of Brasília, DF, 2016 (n=100).

Nature of the violences	Prevalence					Frequency			
	In life	In the last 2 months		Once		2 to 4 times		5 or more times	
	N	n	%	n	%	n	%	n	%
Psychological violence	40	18	45.0	15	37.5	9	22.5	16	27.5
Insult									
Discrimination	35	18	51.4	11	31.3	16	45.7	8	11.4
Physical violence	12	6	50.0	7	58.3	2	16.6	3	16.7
Sexua violence	4	-	-	2	50.0	2	50.0	-	-
Abandonment	31	17	54.8	6	19.3	11	35.4	14	32.3
Negligence	16	10	62.5	3	18.7	8	50.0	5	31.3
Financial abuse	15	6	40.0	7	46.6	3	13.3	5	33.3
Self-neglect	26	9	34.6	12	46.1	9	34.6	5	19.2

Table 4. Distribution of self-perception of quality of life according to the experiences of violence of the elderly in a region of the Metropolitan Area of Brasília, DF, 2016 (n=60).

Variable	Experience with violence						p-value
	Yes (n)	%	No (n)	%	Total	%	
Quality of life and health as "good and very good"	19	40.4	5	38.5	24	40.0	0.8982
Quality of life and health as "bad and very bad"	28	59.6	8	61.5	36	60.0	
Total	47	100	13	10	60	100	

DISCUSSION

It is known that, because the research was carried out with participants of a CCE that develops collective activities and offers social support, it was probably corroborated the finding that the majority declared to be satisfied or very satisfied with the interpersonal relations with friends and and has favored the environment of trust needed to conduct individual interviews with a sensitive topic where approximately four out of five respondents reported having experienced violence after reaching the age of 60. Psychological violence was the most prevalent, and physical or sexual violence presented minor prevalence following the international trend.¹⁴

Over the area under investigation, a population-based survey was conducted, which also indicated a low level of schooling, with incomplete primary education, for almost half the population (48.24%), with only 18.7% of those with a secondary education complete. As for skin color, 74.0% declared themselves to be brown and black. A total of 49.0% came from several regions of Brazil. Of these, the Northeast represented 70.0% of the migrants. The average monthly individual income of heads of households was equivalent to 1.58 minimum wages and showed a territory marked by socioeconomic

vulnerability.¹⁵

Through the CCEs, an essential opportunity for the promotion of the health of the elderly has been represented, which should be increasingly used as a scenario for practices and experiences of health promotion and violence prevention. A study compared with the elderly in Spain and Brazil identified that those affiliated to both groups and living quarters reported greater satisfaction, improved health perception and described networks of relationships as sources of social support and satisfaction with life. The social participation of the elderly favors physical and psychosocial well-being. In the coexistence, opportunities can arise for the mutual strengthening, the exchange of knowledge and information, the solidarity, the expansion of confidence and the aid relations so necessary for the confrontation of the violence.¹⁶

In this study, it should be emphasized that the care of the elderly comes from a family base in the households. In Brazil, the care structure of the elderly still relies heavily on the family. Long-term care facilities for the elderly are not available in sufficient quantity and quality of care for society as a whole, especially for socioeconomically vulnerable populations.¹⁷ A study conducted in the Center-West region of Brazil found similar results among elderly people living with , at

least one member of their family (89%) and with children (94.1%).¹⁸

The family also represents a risk to the safety and integrity of the elderly. In a study based on the denunciation services carried out in a city in the interior of the State of São Paulo, it was observed that the fact that the elderly live in the homes with their children and grandchildren has been shown to be a risk factor related to violence.¹⁹ Other studies have shown the same trend: living with children increases the chance that the elderly will be victims of violence.²⁰⁻²¹ Although the Elderly Statute presents the family as one of the caregivers of this population, the results of research reveal the serious violations of rights practiced by family members in the various cycles of human life, including in old age.^{19,22}

As far as psychological violence is concerned, the study conducted in the same metropolitan area where this study was carried out revealed that 34% of the elderly interviewed had already been victims of humiliation and 26% had suffered discrimination, especially the elderly female.¹⁸

It is noted that, since the population studied is practically homogeneous in its presentation of low income and educational status, the intersectionality issues between age, gender, ethnicity and access to public services need to be discussed together, since they may represent a life of experiences of denial of rights that extend to old age and not necessarily represent a new phenomenon in the lives of the interviewees. It is worth mentioning that low schooling has been pointed out as being associated with the perception of poor quality of life.²²

It is advised that, from a gender perspective, a longitudinal design, through new studies, would help to identify the violence suffered by women practiced by intimate partners and those perpetuated by their children or relatives and to capture the process of violence in the course of life of the elderly women. The greater presence of women in the CCE, and therefore in the study sample, suggests a continuum scenario of the presence of women in collective spaces and health services.²³ Violence identified needs assistance that transcends the work of health professionals and that viable inter-sectoral actions articulated with the focus on prevention, promotion, protection of health and improvement in the quality of life of the elderly with the expansion of access to public health and safety services in the territory.

CONCLUSION

It was evidenced the naturalization of the experiences of violence in the daily life of those interviewed by the magnitude of the phenomenon. Still, most respondents believe that life has meaning, claims to take advantage of it, and is self-satisfied.

It is necessary to develop inter-sectoral activities in the collective of the city and to increase the awareness of health professionals about the opportunities of health promotion in these spaces of coexistence. The community environments favor the contribution of the elderly and enable new relational dynamics to strengthen autonomy and protagonism in access to protection networks and services. The non-trivialization of violence at any stage of life involves learning for a culture of denouncing violence, valuing human dignity and enhancing the quality of life, community health and freedom to live a life free from violence.

In this study, we observed a higher frequency of female, divorced, low educational and family income older adults, where the most frequent type of violence was psychological violence, and the least reported was sexual violence. The majority of the elderly said they were dissatisfied with their health and quality of life and suffered some kind of violence after completing sixty years.

The practical implications of this research are thus demonstrated, since identifying ways to promote the role of the elderly in coping with the violence suffered can contribute to the implementation of assertive actions that result in the integrated action of the multi-professional team to promote health and dignity human.

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